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Houston, TX 77054
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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

(Please Check One)

☐ I,______________________________, have received a copy of Bootin & Savrick's
Patient / Guardian

Notice of Privacy Practices.

☐ I,______________________________, refuse to accept a copy of Bootin & Savrick's
Patient / Guardian

Notice of Privacy Practices.

___________________________ ___________________
Signature of Patient / Guardian Date

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME ____

BIRTHDATE ____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information:**

____

____

____

PATIENT:

X______________________________ ______________ ______________________

Signature of Patient or Legal Representative   Date   Witness Signature

OFFICE USE ONLY:

☐ Accepted

☐ Denied

______________________________ ______________ ______________

Signature   Title   Date

BIOLOGICAL FAMILY HISTORY

DOES ANY FAMILY MEMBER HAVE:	YES	NO	DON'T KNOW	RELATIONSHIP TO CHILD
CHILDHOOD HEARING LOSS				
NASAL ALLERGIES				
ASTHMA				
TUBERCULOSIS				
HEART DISEASE (BEFORE AGE 55 YRS OLD)				
HIGH CHOLESTEROL/TAKES CHOLESTEROL MEDICATION				
ANEMIA				
BLEEDING DISORDER				
DENTAL DECAY				
CANCER (BEFORE AGE 55 YRS OLD)				
LIVER DISEASE				
KIDNEY DISEASE				
DIABETES (BEFORE AGE 55 YRS OLD)				
BED-WETTING (AFTER 10 YRS OLD)				
OBESITY				
EPILEPSY OR CONVULSIONS				
ALCOHOL ABUSE				
DRUG ABUSE				
MENTAL ILLNESS/DEPRESSION				
DEVELOPMENTAL DISABILITY				
IMMUNE PROBLEMS, HIV OR AIDS				
TOBACCO USE				
ADDITIONAL FAMILY HISTORY				

PAST HISTORY

HAS YOUR CHILD EVER HAD:	YES	NO	DON'T KNOW	HAS YOUR CHILD EVER HAD:	YES	NO	DON'T KNOW
CHICKENPOX				SLEEP PROBLEMS; SNORING			
FREQUENT EAR INFECTIONS				CHRONIC OR RECURRENT SKIN PROBLEMS			
PROBLEMS WITH EARS OR HEARING				FREQUENT HEADACHES			
NASAL ALLERGIES				CONVULSIONS OR OTHER NEUROLOGIC PROBLEMS			
PROBLEM W/ EYES OR VISION				OBESITY			
ASTHMA, BRONCHITIS, BROCHIOLITIS, OR PNEUMONIA				HISTORY OR SERIOUS INJURIES/FRACTURES/CONCUSSIONS			
ANY HEART PROBLEM OR HEART MURMUR				USE OF ALCOHOL OR DRUGS			
ANEMIA OR BLEEDING PROBLEM				TOBACCO USE			
BLOOD TRANSFUSION				ADHD/ANXIETY/MOOD PROBLEMS/DEPRESSION			
FREQUENT ABDOMINAL PAIN				DEVELOPMENTAL DELAY			
CONSTIPATION REQUIRING DOCTOR VISITS				DENTAL DECAY			
RECURRENT URINARY TRACT INFECTIONS AND PROBLEMS				HISTORY OF FAMILY VIOLENCE			
KIDNEY DISEASE OR UROLOGIC MALFORMATIONS				HAS YOUR CHILD EVER TESTED POSITIVE FOR TB SKIN TEST			
BED-WETTING (AFTER 5 YRS OLD)							

PROBLEMS WITH PERIODS: **YES** **NO** AGE OF FIRST PERIOD: ____________________

ANY OTHER SIGNIFICANT PROBLEM/SURGERY:

____

____

PLEASE LIST ALL CURRENT MEDICATIONS:

____

____

PATIENT HISTORY

HOUSEHOLD

PLEASE FILL OUT THE FOLLOWING TABLE ACCORDING TO THE HOUSEHOLD MEMBERS ONLY

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS

ARE THERE ANY SIBLINGS NOT LISTED ABOVE? **YES** **NO**

IF YOU ANSWERED YES, PLEASE LIST THEIR NAME, AGE, AND WHERE THEY LIVE

WHAT IS THE PATIENT'S LIVING SITUATION IF NOT WITH BOTH BIOLOGICAL PARENTS?

IF ONE OR BOTH PARENTS ARE NOT LIVING IN THE HOME, HOW OFTEN DOES THE CHILD SEE THE PARENT(S) NOT IN THE HOME?

BIRTH HISTORY

BIRTH WEIGHT ____________
WAS THE PATIENT BORN AT TERM? **YES** **NO**
WAS DELIVERY: **VAGINAL** **CESAREAN**
IF CESAREAN, WHY?

WERE THERE ANY PRENATAL OR NEONATAL COMPLICATIONS? **YES** **NO**
IF YES, EXPLAIN:

WAS A NICU STAY REQUIRED? **YES** **NO**
IF YES, EXPLAIN:

INITIAL FEEDING: **BREAST MILK** **FORMULA**
IF BREAST MILK, HOW LONG DID YOU BREAST FEED?

DURING THE PREGNANCY, THE MOTHER USED:
TOBACCO **YES** **NO**
ALCOHOL **YES** **NO**
MEDICATIONS **YES** **NO**
IF USED MEDICATIONS, PLEASE LIST THEM:

DRUG USE? **YES** **NO**
IF YES, WHAT? ____________________ WHEN? ____________________

GENERAL

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? **YES** **NO** **DON'T KNOW**
IF NO, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITIONS? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD HAD ANY SURGERY? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN:

IS YOUR CHILD ALLERGIC TO MEDICINE OR DRUGS? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN: